

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0701	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/24/2010
NAME OF PROVIDER OR SUPPLIER BEECH TREE MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 240 HOSPITAL LANE, PO BOX 300 JELICO, TN 37762		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
N 000	Initial Comments Complaint investigations #TN00025252; TN00025739; TN00025842; TN00025882; TN00025905; TN00025919; TN00025208; TN00025266; TN00025361; and TN#26104 were completed from June 21, 2010, thru June 24, 2010, at Beech Tree Manor, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000			

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Administrator

(X6) DATE
7-9-10

STATE FORM

6899

JGT411

If continuation sheet 1 of 1

JUL 12 2010